Benefit Choice Options

Local Government Health Plan

Department of Central Management Services
Bureau of Benefits

Effective July 1, 2004 - June 30, 2005

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The State of Illinois intends that the terms of this plan are legally enforceable and that the plan is maintained for the exclusive benefit of Members. The State reserves the right to change any of the benefits and costs described in this Benefit Choice Options Booklet. This Booklet is produced annually and is intended to update the Benefits Handbook. If there is a discrepancy between the Benefit Choice Options Booklet, the Benefits Handbook and state or federal law, the law will control.

Your Responsibilities

Benefit Choice Period is May 31 - June 18, 2004. It is the time of year to review and/or make changes to your health benefit plan. Benefit Choice is the only time, other than a qualifying change in status, that you can change plans or add/drop dependent coverage (see 2000 Benefits Handbook).

Steps to follow to make a Benefit Choice change:

1. **Read the information in this booklet.** It is your responsibility to know the benefit coverages and limitations. If necessary, obtain additional information on the plan in which you are currently enrolled or in which you are considering enrolling.

2. Make your medical plan choices. Review the features below to help you make the best healthcare choices for you and your family. Enrolled dependents are covered by the same medical plan as the member. Plans differ with respect to:

- Services covered
- Deductibles, copayment levels and out-of-pocket maximums
- Geographic limitations
- Healthcare provider network

You have three (3) types of medical plans to choose from:

Managed Care Plans
- Health Maintenance Organizations (HMO)
- Open Access Plan (OAP)

Indemnity Plan
- Local Care Health Plan (LCHP)

Managed care plans have geographic and provider limitations. If you are interested in a managed care plan, you should carefully review the information on page 6 and the Managed Care Plans in Illinois Counties map on page 7. Network provider directories are available from each plan administrator. The LCHP is available regardless of your place of residence.

Remember: There can be changes in your coverage even if you do not change plans. Specific questions regarding coverage should be directed to each respective plan administrator. Telephone numbers and web addresses are listed on page 11.

Note: Dental and vision are included in your coverage. No action is necessary - coverage is automatic with enrollment into a health plan.

3. Complete the Benefit Choice Election Form (new this year) that is located at the end of this booklet. Only complete this form if you want to make a change to your benefits during the Benefit Choice election period. Submit the completed form to your Health Plan Representative (HPR) during the Benefit Choice election period that ends on June 18, 2004.

4. Review the Verification Statement that will be mailed to you from the Department of Central Management Services to confirm your Benefit Choice election changes. This statement will be sent to you after your Benefit Choice election has been processed.

Changes to Your Benefit Elections During the Year.

You may change your benefit elections during the year only if you have a qualifying change in status (life event change) that impacts your benefit needs. You must contact your HPR when one of the following events occur:

- You and/or your dependents have a change of address.
- You experience a life event change that may affect eligibility for you or your dependent(s) such as:
  - birth/adoption of a child, (enrollment for a newborn is not automatic. Contact your HPR within 60 days of birth for coverage to be retroactive to birth).
  - marriage, divorce, legal separation or annulment,
  - death of spouse or dependent,
  - employment status change for you, your spouse or your dependent(s) that affects eligibility under the plan,
  - dependent(s) loss of eligibility,
  - court order resulting in the gain or loss of a dependent,
  - change in Public Aid recipient status,
  - dependent becomes covered by other group health or dental coverage.
- You or your enrolled dependents have other group insurance coverage including Medicare, or gain other coverage during the plan year. Provide a copy of the insurance or Medicare card to your HPR as soon as possible.

Important Benefit Changes For Fiscal Year 2005

The information below represents changes to the Local Government Health Plans (LGHP). Carefully review all the information in this Benefit Choice Options Booklet. **This Booklet contains updates to the Local Government Health Plan Benefits Handbook.** You should review this publication each year to be aware of changes in the benefits available. Benefit Choice is May 31 - June 18, 2004. **All selections made during Benefit Choice will be effective July 1, 2004.**

Changes specific to Managed Care Health Plans (HMO/OAP)

Managed Care Health Plans - the plans that were available last year continue to be available. Several of the plans have expanded their service areas. Managed Care Health Plans will not be sending marketing material automatically. If you need specific information, contact the plan directly or visit **www.benefitschoice.il.gov** for information and links to the Managed Care Health Plan websites. For details on plans in your area, see page 7.

Prescription Drug Benefit - All prescription drug copayments will change to $7.00 Generic, $14.00 Formulary Brand and $28.00 Non-Formulary Brand. Contact your Health Plan Administrators Prescription Benefit Manager for detailed information including the Preferred Drug List (formulary). If enrolled in Healthlink Open Access Plan (OAP) or Health Alliance Illinois , see page 4 for prescription drug information. See page 11 for Plan Administrator information.

Changes specific to the Local Care Health Plan (LCHP)

The LCHP Hospital Preferred Provider Organizations - includes over 200 hospitals statewide. The list is no longer provided in this book. The list is available on-line at **http://provider.healthcare.cigna.com/soi.html**

Local Government Dental Plan (LGDP)

There are no changes to the dental plan. For a detailed description of your dental plan benefits, see the schedule of benefits in the previous year's (FY04) Benefit Choice Options Booklet which is available on-line at **www.benefitschoice.il.gov** or contact your HPR for information**.** Refer to page 9 for details.

Vision Plan

Vision Plan - There are no changes to the vision plan. Vision Service Plan (VSP) will continue to be the Vision Plan Administrator. See page 10 for vision benefit information.

Keep Up-to-Date on Details

To make sure you are provided with the most up-to-date information, you should periodically review the following:

- Annual Benefit Choice Booklet which details changes affecting all benefit programs each plan year.
- Health and dental information from the plan administrators in which you are currently enrolled or considering enrollment.
- Preferred Drug Lists are subject to change during the plan year without notice. Contact your Health Plan Administrator's Prescription Benefit Manager for detailed information.

Frequently Asked Questions (FAQs) about Benefits

1) Who do I contact for more information about my benefits or to make changes to my existing coverage?

Contact the HPR at your employing Unit. Your Unit's personnel or payroll office can assist you in locating your HPR.

2) Do I get a new medical and prescription drug identification card every plan year?

The only times you will receive an identification card are when you first enroll in the plan, if you change plans, if the plan administrator changes or if you request new cards. If you lose your identification card(s), you may request a replacement card(s) from your Medical and Prescription Drug Plan Administrator listed on page 11.

3) I know managed care plans have geographic limitations. Will I have to change plans if I move?

If your current plan is available at your new location, you will remain under that plan unless your Primary Care Physician (PCP) is not accessible to you. Your managed care plan determines whether your PCP continues to be accessible. If your PCP is not accessible, you will need to select a new PCP or change plans. If you move out-of-state or out of the country, you will most likely have to enroll in the LCHP.

4) Is enrollment for my newborn for health coverage automatic?

No, enrollment for a newborn is not automatic. To enroll a newborn, contact your HPR within 60 days of birth for coverage to be retroactive to birth. The newborn's birth certificate is required for enrollment.

5) What should I, or my dependent, do when we turn 65 or become eligible for Medicare due to a medical condition (Medicare Disability or Medicare ESRD)?

In most cases, you must enroll in both Medicare Parts A and B and send a copy of your Medicare card to your HPR. If you or your dependent are actively working and eligible for Medicare or you have additional questions about this requirement, contact the Group Insurance Division, Medicare COB Unit. See page 11 for contact information.

6) My address has changed. What should I do?

Contact your HPR as soon as possible to update your insurance records.

Prescription Drug Plan

Important: Prescription drug benefit for members enrolled in LCHP, Health Alliance Illinois and HealthLink OAP.

Caremark is your Prescription Drug Plan Administrator if you are enrolled in one of the above listed medical plans. If you are not enrolled in one of the above mentioned managed care health plans, contact your health plan Prescription Benefit Manager for detailed prescription information. The coverage provides both in-network and out-of-network benefits. Most drugs purchased with a prescription from a physician or dentist are covered. No over-the-counter drugs will be covered, even if purchased with a prescription. The Preferred Drug List is available from Caremark and is subject to change at any time during the plan year. **Please review the Preferred Drug List and contact your physician to determine if a change in your prescription is appropriate.** To contact Caremark, see page 11.

In-Network Benefits

The pharmacy network consists of retail pharmacies which accept the copayment amounts. For the most up-to-date information on network pharmacies, contact Caremark.

In-network benefits when using the Prescription Drug Identification Card:

– No plan year deductibles; no claim forms to file.

– Flat Copayments (1 to 30-day supply):
- Generic $ 7.00
- Formulary Brand $14.00
- Non-Formulary Brand $28.00

– The maximum days supply available at one fill is 60 days. However, the copayments described above will double for any prescription exceeding 30 days.

– When the pharmacy dispenses a brand drug for any reason, and a generic is available, the plan participant must pay the cost difference between the brand product and the generic product, plus the generic copayment of $7.00.

– If only a brand drug is available, the copayment will be $14.00 or $28.00.

– When the price of a prescription is lower than the copayment, the pharmacist will collect the lower amount.

When medication is purchased at an in-network pharmacy without presentation of the Prescription Drug Identification Card, you will be charged the full retail cost of the medication. The claim will be processed as if the prescription was filled at an out-of-network pharmacy (see Out-of-Network Benefits).

Out-of-Network Benefits

Prescription drugs may be purchased at out-of-network pharmacies. Reimbursement will be at the applicable brand or generic **in-network** price minus the appropriate in-network copayment. In most cases, the cost of the prescription drugs will be higher when not using in-network pharmacies. Prescriptions filled by an out-of-network pharmacy will require the completion of a claim form (available from Caremark) and supporting documentation.

Mail Service Program

Maintenance medications are available through mail order at the following copayments:

– Flat Copayments (90-day supply):
- Generic $14.00
- Formulary Brand $28.00
- Non-Formulary Brand $56.00

Contact Caremark for mail order forms and information.

Coordination of Benefits

This Plan coordinates with Medicare and other group plans; the appropriate copayment will be applied for each prescription filled.

Exclusions

The Plan reserves the right to exclude or limit coverage of specific prescription drugs or supplies.

Medical Plan Comparison

Benefit	LCHP	HMO	OAP Tier I	OAP Tier II	OAP Tier III (Out-of-Network)
Plan Year Maximum Benefit	Unlimited	Unlimited	Unlimited	Unlimited	$1,000,000
Lifetime Maximum Benefit	Unlimited	Unlimited	Unlimited	Unlimited	$1,000,000
Patient Responsibilities					
Annual Out-of-Pocket Maximum • Per Enrollee • Per Family	**General:** $1,000 per enrollee $2,500 per family/plan year Non-PPO Hospital: $4,000 per enrollee $9,000 per family/plan year	$1,500 $3,000	Not Applicable	$1,000 $2,500	$2,000 $5,000
Other Deductibles/Copayments: Emergency Room Non-PPO/Out-of-Network Hosp.Adm.	$250 $250	$150 No Coverage	$150 See Tier III for benefit level	$150 + 10% Network Charges See Tier III for benefit level	$150 + 20% Network Charges $350 + 20% of U&C
Annual Plan Deductible Must be satisfied for all services	$250 Per Enrollee	$0	$0	$300 Per Enrollee	$500 Per Enrollee
Plan Benefit Levels Comparison*					
Inpatient	90% - PPO 80% or 65% - Non-PPO	$200 copayment	$200 copayment	90% of network charges after $250 copayment	80% of U&C after $350 copayment
Outpatient Surgery	90% for PPO Network Provider	$150 copayment	$150 copayment	90% of network charges after $150 copayment	80% of U&C after $150 copayment
Diagnostic Lab & X-ray	80% of U&C	100%	100%	90% of network charges	80% of U&C
Durable Medical Equipment	80% of U&C	80% of network charges	80% of network charges	80% of network charges	80% of U&C
Physician Office Visit	90% PPO 80% of U&C Non-PPO	$20 copayment	$20 copayment	90% of network charges after a $20 copayment	80% of U&C
Preventive Services	80% or 100% for specific services	$20 copayment	$20 copayment	90% of network charges after a $20 copayment	Covered In-Network only
Examples of Out-of-Pocket Expenses*					
$25,000 Expense Inpatient Hospitalization	$1,000 Maximum PPO Out-of-Pocket	$200 Admission Copayment In-Network	$200 Admission Copayment In-Network	$1,000 Maximum Out-of-Pocket In-Network	$2,000 Maximum Out-of-Pocket
$25,000 Expense Inpatient Out-of-Network Hospitalization	$4,000 Maximum Out-of-Pocket	$25,000 No Coverage at an Out-of-Network Hospital	$25,000 No Coverage at an Out-of-Network Hospital	$25,000 No Coverage at an Out-of-Network Hospital	$2,000 Maximum Out-of-Pocket
$15,000 Expense Outpatient Surgery	$1,000 Maximum PPO Out-of-Pocket	$150 Copayment In-Network	$150 Copayment In-Network	$1,000 Maximum Out-of-Pocket In-Network	$2,000 Maximum Out-of-Pocket
$1,000 Expense Emergency Room Visit	$325 ($250 ER Deductible + 10% PPO Coinsurance)	$150 Copayment In-Network	$150 Copayment In-Network	$235 ($150 Copayment + 10% of Network Charges)	$320 ($150 Copayment + 20% U&C)

*Note: Benefit Levels are general guidelines and for comparison purposes only. These examples make assumptions and each claim is unique. Contact the plan administrator for specific coverage details. Each example assumes the annual plan deductible has been met. The cost estimates in each example represent the U&C (LCHP & TIER III) and network (HMO & TIERS I & II) charges for facilities only. The examples do not include physician charges.

Managed Care Plans

There are 7 managed care plans from which to choose. Plans include Health Maintenance Organizations (HMOs) and an Open Access Plan (OAP). All offer comprehensive benefit coverage.

There are distinct advantages to selecting a managed care health plan – namely, lower out-of-pocket costs and virtually no paperwork. Like any health plan option, managed care has its limitations including geographic availability and limited provider networks. If you are considering a managed care plan you should explore and research the various plans available. Benefits are subject to the limitations outlined in the plan's Certificate of Coverage. Contact the managed care plan administrator for detailed information concerning the various level of coverage provided, see page 11.

Health Maintenance Organizations (HMOs)

HMOs operate on an "in-network" structure. Members select a Primary Care Physician (PCP) from the network of participating providers. In conjunction with the health plan, the PCP directs all healthcare services for the member, including visits to specialists and hospitalizations. When care is coordinated through the PCP, the member pays only a predetermined copayment. There are no annual plan deductibles for HMO plans.

Open Access Plan (OAP)

The plan is unique because it offers three benefit levels:

Tier I - offers the highest level of benefits - often 100% after a copayment if you use a Tier I network provider.

Tier II - generally pays at 90%, after you pay a deductible, if you use a Tier II network provider.

Tier III - gives you the flexibility of using an out-of-network provider. Benefits are generally paid at 80% of the usual and customary charges after you pay a deductible.

The plan provider directory contains separate listings of providers in the Tier I and Tier II networks so that you will know in advance the level of benefits you will receive. Another advantage of selecting the network providers is that they have met strict accreditation standards.

Important Reminders About Managed Care Plans

Provider Network Changes: Managed care plan provider networks are subject to change. **Always call the respective plan to verify participation of particular providers** - even if the information is printed in the plan's directory.

PCPs Leaving a Network: If your PCP leaves the managed care plan's network, you have three options: 1) choose another PCP within that plan; 2) change managed care plans; or 3) enroll in the Local Care Health Plan. The opportunity to change plans applies **only to PCPs leaving the network.** It does not apply to specialists or women's healthcare providers who are not designated as PCPs.

Out-of-County Managed Care Plans: If you are interested in enrolling in a managed care plan that is not available in your county of residence, contact the plan directly for more information.

Dependents: Eligible dependents who live apart from your residence for any part of a plan year may be subject to limited service coverage. It is critical to contact the managed care plan that you are considering to understand the plan's guidelines on this type of coverage.

June/July Hospitalizations: If you change health plans and you or your dependents are hospitalized in June, it is recommended you contact both your current plan/PCP and future plan/PCP well in advance.

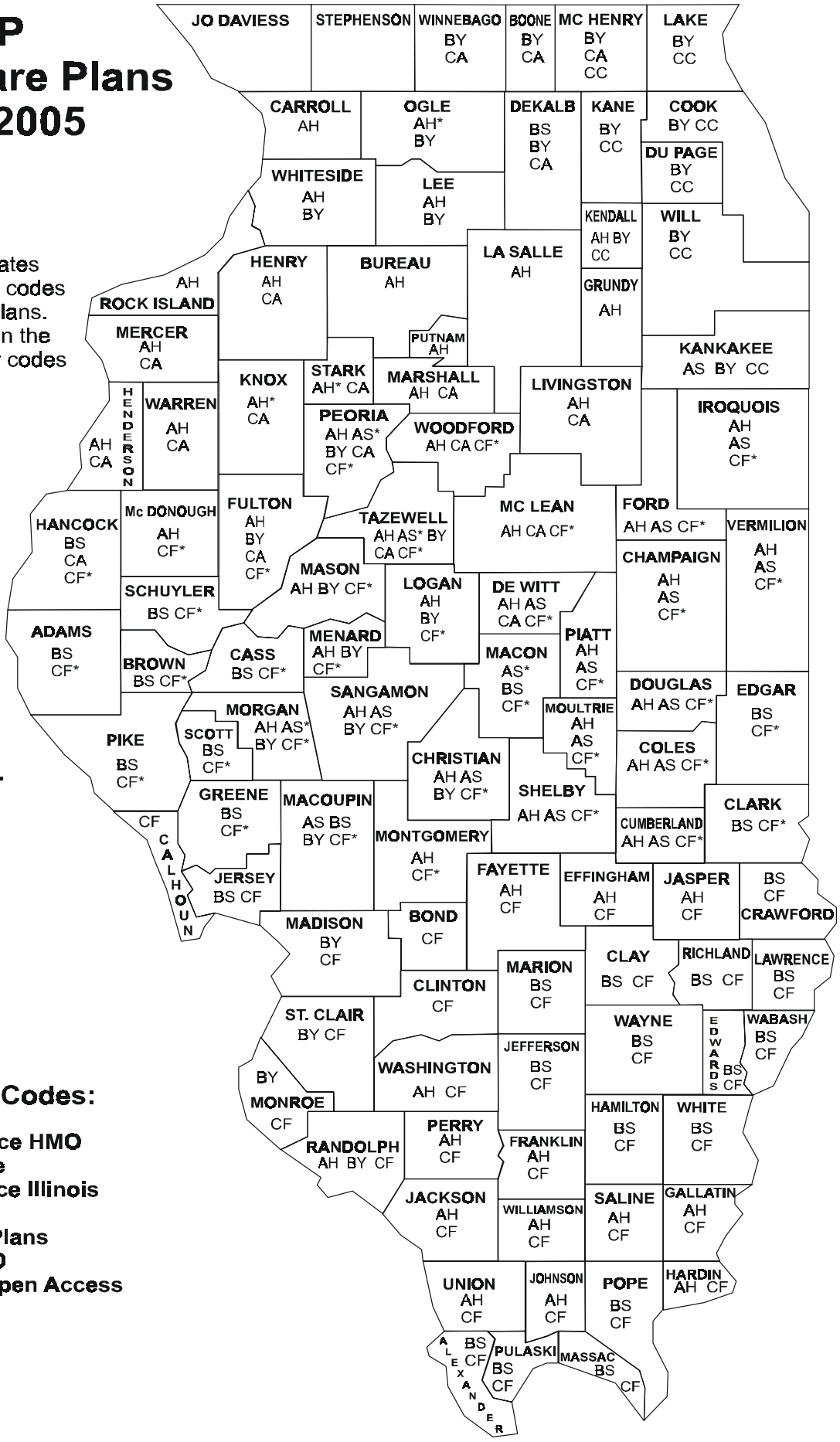
Plan Year Limitations: Certain managed care plans may provide benefit limitations on a **calendar year.** In certain situations, the State's plan year may not coincide with the managed care plan's year.

Transition of Services: If you know you are switching plans and you or your dependents are involved in an ongoing course of treatment or have entered the third trimester of pregnancy, it is imperative that you contact the new plan to coordinate the transition of services for your care.

LGHP Managed Care Plans For FY 2005

The key below indicates the two-letter carrier codes for HMO and OAP plans. Plans are available in the counties where their codes appear.

*** If an asterisk appears by one of the managed care plans, it means the plan is new to that county.**



HMO and OAP Codes:

AH = Health Alliance HMO
AS = PersonalCare
BS = Health Alliance Illinois
BY = HMO Illinois
CA = OSF Health Plans
CC = UniCare HMO
CF = HealthLink Open Access

The Local Care Health Plan (LCHP)

LCHP is a medical indemnity plan which offers a comprehensive range of benefits. The LCHP Medical Plan Administrator is CIGNA. Under LCHP, you choose any physician or hospital for general or specialty medical services, and receive enhanced benefits by using a LCHP Preferred Provider Organization (PPO) hospital or the CIGNA Healthcare PPO Network of providers and facilities. Magellan Behavioral Health is the LCHP Behavioral Health Administrator and is the Notification Administrator for mental health/substance abuse services. Intracorp is the LCHP Notification Administrator/Medical Case Management Administrator.

LCHP - Avoiding Monetary Penalties Through Notification

Notification is your telephone call to the Notification Administrator, informing them of an upcoming admission to a facility such as a hospital or skilled nursing facility, or for a specified outpatient procedure, and for all levels of care for mental health/substance abuse services. Notification is your responsibility and avoids monetary penalties and maximizes your benefits.

There are certain situations where you must call the Notification Administrators to avoid a $400 penalty and the risk of incurring non-covered charges for services not considered medically necessary. Examples may include an upcoming admission to the hospital (including a planned admission as well as an emergency or urgent admission) or skilled nursing facility, or if you are having certain procedures performed, such as maternity, surgery, whether emergency or non-emergency, an outpatient MRI, PET, SPECT and CAT scan, potential transplant procedure and infertility treatment.

Please review pages 40-41 and 57-59 of your 2000 Benefits Handbook for further details. See page 11 for Plan Administrator information.

LCHP- Hospital Preferred Provider Organizations (PPO)

A network of hospitals is available and provides an enhanced benefit of 90% by using a participating network provider. The network includes over 200 hospitals statewide. The Hospital PPO List is available on CIGNA's website. See page 11 for information.

LCHP- CIGNA HealthCare PPO Networks

LCHP non-Medicare members have available **nationwide** CIGNA HealthCare PPO providers, hospitals and facilities. An enhanced 90% benefit for professional fees, hospital and facility services is available by using a participating network provider. The questions and answers below provide more information about this benefit feature. If you have additional questions contact CIGNA, see page 11.

What is the CIGNA HealthCare PPO Network?

The CIGNA HealthCare PPO Network is a nationwide network of physicians, hospitals and facilities that have agreed to participate at negotiated rates offering members an enhanced benefit.

What are the advantages of using a CIGNA HealthCare PPO Network provider?

The advantages of using providers participating in the network are that benefits for covered services are generally paid at 90% of a negotiated fee and usual and customary limits will not be applied.

How do I access services from a CIGNA HealthCare PPO Network provider?

Just make an appointment with a network provider and present your Local Care Health Plan identification card at the time of service.

What if I do not use a CIGNA HealthCare PPO Network provider?

Standard plan benefits, coinsurance levels, and usual and customary limits apply.

How can I find out which providers are participating in the CIGNA HealthCare PPO Network?

Access the CIGNA Healthcare PPO Network participating provider list on CIGNA's website. See page 11 for information.

Dental Plan

Local Government Dental Plan (LGDP)

Everyone is automatically enrolled in LGDP. LGDP is administered by CompBenefits. Under LGDP, you may go to any dentist and receive benefits for an extensive range of services. LGDP reimburses covered services at a predetermined maximum allowable scheduled amount. You are responsible for any charges over the scheduled amount. For a detailed description of your dental plan, see the schedule of benefits in the previous year's (FY04) Benefit Choice Options Booklet, contact your HPR or CompBenefits.

Benefits

Plan Design	Local Government Dental Plan (LGDP)
Annual Deductible	$50 individual plan deductible for dental services other than those listed as "preventive or diagnostic" on the Schedule of Benefits.
Maximum Benefit Limit	$1,200 per person per plan year after plan deductible. $2,000 combined maximum, after deductible, on prosthetic, periodontic, surgical extraction and general anesthesia services accumulated every five years.
Maximum Benefit Level for Child Orthodontics (under age 19)	$1,500 lifetime maximum depending on length of treatment after plan deductible. Orthodontic benefits count toward maximum annual benefits above. Contact CompBenefits for a pre-treatment estimate.
Claim forms	Required
Dentist selection	Choice of provider

Maximum benefits apply after required deductibles are met. All benefits are subject to LGDP exclusions (see page 77 of the 2000 Benefits Handbook).

Vision Plan

Eye examinations are an important part of your overall health, protecting your visual wellness and providing early detection of serious health conditions. The vision plan provides coverage for an eye exam, lenses and a frame or contact lenses once every twenty four months.

VSP is the Vision Plan Administrator. See page 11 for information.

Eligibility

All members and dependents covered by any of the health plans offered by the LGHP are eligible for the vision care benefit.

Covered Services

There are specific definitions of lenses, contact lenses, both medically necessary and elective, and frames. There are also time limits for filing claims for out-of-network services. Read page 31-32 of the 2000 Benefits Handbook for details.

Schedule of Benefits

Service	In-Network Benefit	Out-of-Network Benefit
Exam	$10 Copayment	$20 Allowance
Lenses*		
Single	$10 Copayment	$20 Allowance
Bifocal	$10 Copayment	$30 Allowance
Trifocal	$10 Copayment	$30 Allowance
Frames*	$10 Copayment for frames within the benefit selection	$20 Allowance
Contact Lenses* Medically Necessary	$20 Copayment	$70 Allowance
Contact Lenses* Elective		
Hard, Soft Daily Wear or Gas Permeable	$50 Copayment	$70 Allowance
All Other Contact Lenses	$70 Allowance	$70 Allowance

*** Refer to your 2000 Benefits Handbook for coverage limits or contact VSP.**

Who to call for information...Plan Administrators

Plan Component	Contact For:	Plan Administrator's Name and Address	Customer Service Phone Numbers and Web Site Address
Local Care Health Plan (LCHP) Medical Plan Administrator	Medical service information, claim forms, ID cards, claim filing/resolution, and pre-determination of benefits.	**CIGNA** Group Number 2457474 CIGNA HealthCare P.O. Box 5200 Scranton, PA 18505-5200	(800) 962-0051 (nationwide) (800) 526-0844 (TDD/TTY) http://provider.healthcare.cigna.com/soi.html
LCHP Notification and Medical Case Management Administrator	Notification prior to hospital services. Non-compliance penalty of $400 applies.	**Intracorp, Inc.** (no address required)	(800) 962-0051 (nationwide) (800) 526-0844 (TDD/TTY) http://provider.healthcare.cigna.com/soi.html
Prescription Drug Plan Administrator	Information on prescription drug coverage, pharmacy network, mail order drug, specialty pharmacy, ID cards and claim forms filing.	**Caremark, Inc.** Group Number 1401 Paper Claims: P.O. Box 686005 San Antonio, TX 78268-6005 Mail Order Prescriptions: P.O. Box 7624 Mt. Prospect, IL 60056-7624	(866) 212-4751 (nationwide) (800) 231-4403 (TDD/TTY) www.caremark.com
LCHP Behavioral Health Administrator	Mental Health and Substance Abuse notification, authorization, claim forms and claim filing/resolution.	**Magellan Behavioral Health** Group Number 2457474 P.O. Box 2216 Maryland Heights, MO 63043	(800) 513-2611 (nationwide) (800) 526-0844 (TDD/TTY) www.MagellanHealth.com
Local Government Dental Plan (LGDP) Administrator	Dental services, claim forms, ID cards and filing.	**CompBenefits** Group Number 960 P.O. Box 4721 Chicago, IL 60680-4721	(800) 999-1669 (312) 829-1298 (TDD/TTY) www.compbenefits.com
Vision Plan Administrator	Vision services, benefits, network providers, claim forms and filing.	**Vision Service Plan (VSP)** P.O. Box 997105 Sacramento, CA 95899-7105	(800) 877-7195 (800) 428-4833(TDD/TTY) www.vsp.com
General Information	General information on the local government health plans, Medicare COB or other benefits.	**CMS Group Insurance Division** P.O. Box 10105 201 E. Madison Street Springfield, IL 62791	(217) 782-2548 (800) 442-1300 (800) 526-0844 (TDD/TTY)

Healthcare Plan Name/Administrator	Toll-Free Telephone Number	TDD / TTY Number	Web Site Address
Health Alliance HMO	(800) 851-3379	(217) 337-8137	www.healthalliance.org
Health Alliance Illinois	(800) 851-3379	(217) 337-8137	www.healthalliance.org
HealthLink OAP	(800) 624-2356	(800) 624-2356, ext 6280	www.healthlink.com
HMO Illinois	(800) 868-9520	(800) 888-7114	www.bcbsil.com/stateofillinois
OSF Health Plan	(888) 716-9138	(888) 817-0139	www.osfhealthplans.com
PersonalCare	(800) 431-1211	(217) 366-5551	www.personalcare.org
Unicare HMO	(888) 234-8855	(312) 234-7770	www.unicare.com

Local Government Health Plan
BENEFIT CHOICE ELECTION FORM
May 31 June 18, 2004 (Changes effective July 1, 2004)
COMPLETE THIS FORM ONLY TO MAKE A *CHANGE* IN YOUR BENEFITS

SECTION A: EMPLOYEE INFORMATION (required)

Social Security Number	Last Name	First Name	Phone Numbers
- -			Home:
			Work:

SECTION B: HEALTH PLAN ELECTION (complete only if changing health plans)

(1) If you are changing to a managed care plan from the Local Care Health Plan (LCHP), or if you are changing to a different managed care plan, you must enter the 6-digit Primary Care Physician (PCP) number.
(2) If you have Medicare or other insurance, you must give your Health Plan Representative (HPR) a copy of your Medicare/other insurance card.

HEALTH PLAN ELECTION			
☐ LCHP			
Managed Care Plans: ☐ HMO ☐ OAP	Carrier Code:____ (see page 7)	Plan Name:	6-digit PCP #:

SECTION C: DEPENDENT INFORMATION (dependent must enroll in the same plan as the member)

(1) You must provide documentation to add dependents – see the back of this form for specific documentation requirements.
(2) If the dependent has Medicare or other insurance, you must give your HPR a copy of the Medicare/other insurance card.
(3) If you are changing to a managed care plan from the LCHP, or if you are changing to a different managed care plan, you must enter the 6-digit PCP number for each dependent in your plan.

Health			Name	SSN	Birth Date	Relationship *	6-digit PCP #
Add	Drop	Change					
☐	☐	☐					
☐	☐	☐					
☐	☐	☐					
☐	☐	☐					
☐	☐	☐					

* Spouse, son, daughter, stepchild, adopted child

This authorization will remain in effect until I provide written notice to the contrary. The information contained in this form is complete and true. I agree to abide by all Local Government Health Plan rules. I agree to furnish additional information requested for enrollment or administration of the plan I have elected.

MEMBER SIGNATURE: _____ DATE: _____

HPR SIGNATURE: _____ DATE: _____

Give completed form to your HPR in your Unit by June 18, 2004.

BENEFIT CHOICE ELECTION FORM
INSTRUCTION SHEET

If you are keeping your current coverage elections, you do not need to complete this Benefit Choice Election Form.

SECTION A EMPLOYEE INFORMATION:

Complete all fields.

SECTION B HEALTH PLAN ELECTION:

Do not complete this section if you only want to change your PCP you must contact the managed care plan directly in order to make this change.

If you wish to change your health plan, check the appropriate box - LCHP, HMO or OAP. If electing/changing managed care plans, you must enter the managed care plan name, the carrier code and the 6-digit PCP number. The carrier code can be found on page 7 of this booklet. The 6-digit PCP number may be found in the managed care plan provider directory or the plan s online website (see page 11 of this booklet for Plan Administrator contact information).

SECTION C DEPENDENT INFORMATION:

Complete this section if you are adding or dropping health coverage for a dependent. If you are adding dependent health coverage, **you must provide the appropriate documentation as indicated below:**

Spouse	Marriage certificate
Natural Child through Age 18	Birth certificate
Stepchild	Birth certificate, marriage certificate indicating your spouse is the child s parent, and proof the child resides with you at least 50% of the time.
Adopted Child	Adoption certificate stamped by the circuit clerk.
Adjudicated Child	Court documentation signed by a judge.
Student	Birth certificate, Dependent Coverage Certification Statement (CMS-138)*, and verification of full-time student enrollment in an accredited school.
Handicapped	Birth certificate, Dependent Coverage Certification Statement (CMS-138)*, and a letter from the doctor 1) detailing the dependent s limitations, capabilities and onset of condition from a cause originating prior to age 19, 2) a diagnosis from a physician with an ICD-9 diagnosis code, and 3) a statement from the Social Security Administration with the Social Security disability determination.
* The Dependent Coverage Certification Statement (CMS-138) is available from your HPR.	

SIGNATURE:

You must sign and date the Benefit Choice Election Form and give to your HPR by **June 18, 2004** in order for your elections to be effective July 1, 2004. Dependent documentation must be submitted to your HPR within 10-days of the end of the Benefit Choice Period. If documentation is not provided within the 10-day period your dependents will not be added.

Illinois Department of Central Management Services
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